



Seattle Childrens MRN:	Seattle Children's Account #	SCH log-in performed by:	Date:
FAILURE TO COMPLETE MAY DELAY RESULTS			
Patient's Last Name	First	Middle	Birth date (required)
Outside Patient Number	Outside Specimen Number	Send Report To:	
Referring Provider	Address:		
Provider Phone Number	DIAGNOSIS / ICD-9:	Phone/Fax:	
IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON BACK			
FAX ADDITIONAL RESULTS TO:		HEALTHCARE PROFESSIONAL TO CALL FOR INFO/ABNORMAL RESULTS:	
NAME (please print): _____		NAME (please print): _____	
FAX #: _____		PHONE #: _____	

SPECIMEN INFORMATION

Date collected: ____ / ____ / ____ Specimen Type: EDTA Extracted DNA Cultured Amniocytes Other:
 Time collected: _____ ACD Cultured Skin Fibroblasts Cultured CVS _____

PATIENT / FAMILY HISTORY

REASON FOR STUDY: Diagnostic Carrier Testing (affected family member) Prenatal testing (Consent form required)
 Carrier Testing (no family history) LMP: _____ EDC: _____

CLINICAL FINDINGS: _____

ETHNICITY (check all that apply): African American Ashkenazi Jewish Asian European Caucasian
 Hispanic Native Alaskan Native American Indian Pacific Islander Other: _____

HISTORY (or attach pedigree): Indicate results of previous genetics studies, dates and case numbers, and where the studies were performed.

DNA ANALYSIS

CPT1A <input type="checkbox"/> CPT1A (Carnitine Palmitoyltransferase Ia) p.P479L, p.G710E	MATCONTAM <input type="checkbox"/> Maternal Cell Contamination
DIABETES TESTING:	MTHFR DNA <input type="checkbox"/> Methylene tetrahydrofolate reductase (c.677C>T, c.1298A>C)
<input type="checkbox"/> MODY Panel (HNF1A, GCK, HNF4A)	MD DNA <input type="checkbox"/> Duchenne/Becker Muscular Dystrophy
<input type="checkbox"/> Neonatal Diabetes Panel (KCNJ11, INS, ABCC8, GCK)	POLG1 SEQ <input type="checkbox"/> Polymerase Gamma 1 Sequencing Analysis
<input type="checkbox"/> Individual Diabetes Gene Sequencing (please indicate gene):	POLG1 KN <input type="checkbox"/> Polymerase Gamma 1 Known Mutation Analysis
<input type="checkbox"/> ABCC8 <input type="checkbox"/> GCK <input type="checkbox"/> HNF1A <input type="checkbox"/> HNF4A <input type="checkbox"/> INS <input type="checkbox"/> KCNJ11	Please specify: _____
<input type="checkbox"/> Known Diabetes Mutation please specify: _____	POLG2 SEQ <input type="checkbox"/> Polymerase Gamma 2 Sequencing Analysis
DNA BANK <input type="checkbox"/> DNA Banking ONLY (Separate Consent Form Required)	POLG2 KN <input type="checkbox"/> Polymerase Gamma 2 Known Mutation Analysis
F V LEIDEN <input type="checkbox"/> Factor V Leiden (p.R506Q)	Please specify: _____
FRAGX DNA <input type="checkbox"/> Fragile X (A & E)	POMPE SEQ <input type="checkbox"/> Pompe Sequencing Analysis
FRAGX DNA <input type="checkbox"/> Fragile X E ONLY	POMPE KNWN <input type="checkbox"/> Pompe Known Mutation Analysis
FA <input type="checkbox"/> Friedreich's ataxia (GAA expansion only)	Please specify: _____
GALT DNA <input type="checkbox"/> Galactosemia (8 mutations)	PTV DNA <input type="checkbox"/> Prothrombin Variant (Factor II), Mutation Analysis (20210G>A)
GALT DNA 1 <input type="checkbox"/> Galactosemia, known mutation analysis	PWS-AS <input type="checkbox"/> DNA Methylation study (check one or both) <input type="checkbox"/> Angelman <input type="checkbox"/> Prader-Willi
Please specify: _____	AGXT SEQ <input type="checkbox"/> Primary Hyperoxaluria Type 1 Sequencing Analysis
GAUCHE DNA <input type="checkbox"/> Gaucher Disease (11 mutations)	AGXT KNOWN <input type="checkbox"/> Primary Hyperoxaluria Type 1, Known Mutation Analysis
GAUCHESEQ <input type="checkbox"/> Gaucher Disease Sequencing Analysis	Please specify: _____
GAUCHE KNWN <input type="checkbox"/> Gaucher Disease, Known Mutation Analysis	ALDH7A1 <input type="checkbox"/> Pyridoxine-Dependent Seizures Sequencing Analysis
Please specify: _____	ALDH7A1 KN <input type="checkbox"/> Pyridoxine-Dependent Seizures, Known Mutation Analysis
LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHA) Sequencing Analysis	Please specify: _____
LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHB) Sequencing Analysis	SMA <input type="checkbox"/> Spinal Muscular Atrophy (Diagnostic)
LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHA + HADHB) Sequencing	SMACARRIER <input type="checkbox"/> Spinal Muscular Atrophy Carrier Testing
<input type="checkbox"/> Simultaneous	THROMB DNA <input type="checkbox"/> Thrombosis Risk Panel (FV Leiden, PTV DNA, MTHFR DNA)
<input type="checkbox"/> Sequential (please indicate order) _____	TYR DNA <input type="checkbox"/> Tyrosinemia type 1 (7 mutations)
LCHAD KNWN <input type="checkbox"/> LCHAD/TFP Known Mutation Analysis	VLCAD SEQ <input type="checkbox"/> VLCAD DNA Sequencing Analysis
Please specify: HADHA _____	VLCAD KNWN <input type="checkbox"/> VLCAD, Known Mutation Analysis
HADHB _____	Please specify: _____
MCAD <input type="checkbox"/> MCAD Mutation Panel (2 mutations)	ATP7B SEQ <input type="checkbox"/> Wilson Disease Sequencing Analysis
MCAD KNOWN <input type="checkbox"/> MCAD, Known Mutation Analysis	ATP7B KKNWN <input type="checkbox"/> Wilson Disease, Known Mutation Analysis
Please specify: _____	Please specify: _____
MCAD SEQ <input type="checkbox"/> MCAD Sequencing Analysis	OTHER: _____

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY:

ALL SAMPLES WILL BE BILLED TO THE REFERRING INSTITUTION UNLESS COMPLETE BILLING AND DIAGNOSIS INFORMATION IS PROVIDED ON THIS FORM. CONTACT SEATTLE CHILDREN'S LABORATORY COMMUNITY SERVICE COORDINATOR FOR ADDITIONAL ASSISTANCE. (206) 987-2102

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

ALL INFORMATION MUST BE COMPLETE

BILL TO: Patient Insurance (attach copy of card) DSHS (attach coupon)
 Referring Institution (provide billing address if different from report address) Seattle Children's is able to bill Medicaid from Alaska, Idaho, Montana & Washington only

Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients

Guarantor/Insurance Subscriber	
Subscriber Date of Birth	Relationship to patient
Address	
Phone Number	Employer
Insurance Company/Medical Coverage	
Claims Address	
Policy Number	Group Number
Primary Care Physician	Phone Number

DNA ANALYSIS SAMPLE INFORMATION:

PLEASE REFER TO www.seattlechildrens.org/geneticslab FOR COMPLETE TEST INFORMATION, SPECIMEN REQUIREMENTS, ADDITIONAL FORMS & SPECIAL INSTRUCTIONS

DNA TESTS

Blood Specimens: 5 mL ACD or EDTA whole blood. Keep specimens at room temperature. Transport specimens to laboratory immediately
****Sodium Heparin (green top) tubes are NOT acceptable for DNA tests.***

Also accepted: Extracted DNA - minimum 10 ug, ship room temperature
Cultured cells - 2 T25 flasks, ship room temperature. Prenatal samples MUST be approved by genetic counselor or lab director and consent form is required.

CONTACT INFORMATION:

If you have questions or wish to consult the staff about the testing or specimen requirements, please call:

Lisa Sniderman-King, MSc, CGC	(206) 987-1406
Molecular Genetics Lab	(206) 987-3872
Sihoun Hahn, MD PhD	(206) 987-7610

SHIP OVERNIGHT AT ROOM TEMPERATURE TO:



Laboratory A-6901
4800 Sand Point Way NE
SEATTLE, WA 98105
(206) 987-2102

*****PEDIGREE DIAGRAM (Only one needed per family)*****